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Testimony for the Record

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Chairman Pitts, Ranking Member Pallone, members of the Subcommittee, and honored guests, my name is Gregory Schimizzi and I am testifying in front of you today as a member of the Board of Directors and Past President of the Coalition of State Rheumatology Organizations (CSRO) and as a private practice rheumatologist at the Carolina Arthritis Associates in Wilmington, North Carolina. The CSRO would like to thank the House Energy and Commerce Subcommittee on Health for taking an in-depth look at innovations in the practice and delivery of medicine and considering how the legislative and regulatory framework should adapt to support improved communication and collaboration. The CSRO appreciates the opportunity to share our views related to barriers to ongoing evidence development, communication, and transparency. Specifically, I will focus on situations in which valid communication pathways are being hampered by outdated practices of the Food and Drug Administration (FDA), as well as

touch upon some unintended consequences of the Sunshine Act, or 'Open Payments,' as implemented by the Centers for Medicare and Medicaid Services (CMS).

For your reference, the CSRO is a group of state or regional professional rheumatology societies formed to advocate for excellence in rheumatologic disease care and to ensure access to the highest quality care for the management of rheumatologic and musculoskeletal diseases. We represent 28 state and regional rheumatology societies in the country. The CSRO's mission is to promote access to the highest quality care for patients with autoimmune inflammatory and musculoskeletal diseases. The CSRO is also a member of the Alliance of Specialty Medicine which represents more than 100,000 practicing specialist physicians in the United States. In addition, I am one of the founding members of Carolina Arthritis Associates in Wilmington, North Carolina, which is a private rheumatology practice with 23 years of service to patients with disabling, disfiguring, inflammatory and destructive autoimmune diseases. I am also a member of the North Carolina Arthritis Association and the American College of Rheumatology.

BACKGROUND

It is the mission of physicians in all specialties to use the safest and most effective means to assist patients in health maintenance, disease prevention, effective disease management and accessing curative therapies. Most of these endeavors are accomplished with the use of treatment modalities that are not only the standard of care but also FDA approved. However, in instances and circumstances where no definitive FDA-approved indication is available, the use of medically accepted alternative uses of approved medicines is often necessary.

Non-approved use of medical products has actually become the standard of care in the treatment of many orphan diseases and also frequently used when standard, accepted treatments fail in common diseases. In my specialty of rheumatology, there are many diseases where little or no scientific or clinical information is present regarding the treatment of certain autoimmune diseases, including Sjögren's syndrome, Behcet's disease, many forms of vasculitis, inflammatory muscle diseases, scleroderma, calcium pyrophosphate deposition disease and other conditions. Given the small patient population, manufacturers may not consider pursuing new indications for a pharmaceutical agent economically feasible since the costs of such endeavors are daunting. Despite the lack of FDA approved indications, those patients still require treatment and, as their physicians, we endeavor to use whatever information is available to help with informed decision-making. For instance, many non-approved indications can be found in standard textbooks of medicine and surgery in all specialties and subspecialties for patients of all ages and are the generally accepted standard of medical care.

The use of medical products, devices and medications is always undertaken using the best available clinical evidence, judgment and consideration with the utmost care, thoughtfulness and regard for patient safety. These decisions take into consideration the patient's comorbid conditions and concomitant medical therapies. In some patients with orphan diseases or illnesses that are poorly understood, non-approved therapies are the only treatments available. Management modalities for these are frequently publicized in scientific meetings, peer-reviewed literature and other compendia. Publicizing these treatments is an important method of communicating effective treatments in the medical community and a source of investigational stimulation to academicians and clinicians into new areas of research and development.

The goals of medicine and medical research in these areas must continue to be the improvement of health of our population, prevention of disease, and the safest and most effective treatment for individuals afflicted with any illness or condition. It is my belief and that of my colleagues that open discussions and distribution of truthful scientific information is a cornerstone to achieve those goals where sound research and data have been completed but it must be shared and distributed.

FOOD AND DRUG ADMINISTRATION

As a member of the Alliance of Specialty Medicine, the CSRO supports the Alliance's recently developed position statement focused on Physician-Directed Applications (also known as "off-label use"), which is included in the appendix of my testimony. One key component of that position statement is that "[i]f specialty physicians use a product for an indication not in the approved or cleared labeling, they have the responsibility: (1) to be well informed about the product; (2) to base its use on a firm scientific rationale and sound medical evidence; and (3) to maintain awareness of the product's use and effects." I agree wholeheartedly with this requirement and would like to highlight some potential problems with recent Food and Drug Administration (FDA) requirements which may hamper my ability as a physician to be well informed about a product and to base its use on firm scientific rationale and sound medical evidence.

My understanding is that the FDA does not allow pharmaceutical companies to actively distribute any key information, even if it is related to the on-label indication, unless it is explicitly referenced in the package insert. Therefore, observational data, subpopulation information, comparative data derived from clinical trials other than randomized controlled trials, and pharmacoeconomic or comparative cost data cannot be proactively shared with clinicians unless such data is directly referenced in the package insert. Further, for medically acceptable alternative uses, such as those which may be referenced in various compendia or practice guidelines as an appropriate treatment, that data can only be shared if a clinician directly and specifically requests such information. By limiting the sharing of information, physicians are hampered in their ability to access all available sound medical evidence and firm scientific rationale necessary to treat patients with difficult problems.

For example, one of our distinguished colleagues attempted to proactively request information to aid in the treatment of a patient with sclerits, which is an inflammatory disease of the eye that can occur in diseases such as rheumatoid arthritis. Left untreated this condition has potentially devastating consequences including complete loss of vision or even perforation of the eye itself. Due to current regulations and limitations that require a physician to explicitly request information, effective treatment of this patient's condition was delayed. This particular patient did not immediately respond to traditional therapy options, but our colleague remembered a presentation suggesting that rituximab may be a suitable physician-directed application. After several failed attempts to contact the speaker, he contacted the pharmaceutical company directly and requested any specific data that the manufacturer possessed relating to this specific potential use. He received the required information, and the product helped his patient. However, the 2-3

weeks required to obtain all of the necessary information, patient consent, and then insurance authorization, caused unnecessary delays in treating his patient and impacted the outcome by delaying access to safe effective care.

It would be preferable to allow the pharmaceutical company with its wealth of information to share key data in order to inform and assist in decision–making. That is not to say that I would recommend a change in all of the current requirements for the FDA to review such information to ensure that it is truthful and not misleading. **The CSRO urges the FDA to expand the current process of review of materials beyond what is included in the package insert to also cover other key data.** The FDA review process should be in real-time and not potentially delayed for a year or more. In addition, **The CSRO urges the FDA, through a public process, to develop standards for qualifying real world data, so that clinicians can be better informed.** With additional comparative effectiveness research, the focus on quality outcomes, and other health care reforms, Congress and the FDA should be encouraging the exchange of scientific information, not hampering it. Blocking access to data on medically acceptable alternative uses seem to countermand these new requirements and complicate my ethical responsibility to provide patients with information on risks, benefits and alternatives to medical treatments as part of the informed consent process. As we move closer to newer, alternative payment models (APMs), where shared decision-making tools will likely be a key component, I am concerned about how this lack of information will impact my ability to truly educate my patients on their options and give them a fair opportunity to engage in the establishment of their care plan.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Next, I would like to discuss the Physician Sunshine Act, or 'Open Payments,' administered by the CMS. In April, my mother-in-law was pleased to share with me an article on the front page of our local paper vilifying me for inappropriate Medicare payments. The article highlighted that I had received $1.49 M in Medicare reimbursements for 2012. What it failed to disclose and characterize was that those reimbursements not only covered payments for my services but, more importantly, covered the Medicare reimbursements for very expensive medications which my patients received. Thus, despite my mother-in-law's hopes, my salary from Medicare was not $1.49 M in 2012. While I and other physicians similarly mentioned in newspaper articles across the entire country received apologies from CMS regarding the inappropriate use of this information, I am not sure if Congressional members realize all of the unintended consequences and mischaracterizations that may result from the release of such information or how easily this information can be misused. I realize that my example is not directly related to the Open Payments program, but I wanted to highlight this situation to Congress before the public release of the Open Payments on September 30, 2014. I fear that similar situations will be common once the Open Payments information is publicly released.

As part of the Affordable Care Act, Congress required the Administration to set up a process by which transfers of value from certain covered entities (primarily manufacturers of drugs and devices) to physicians would be reportable. Such reportable information would then be made publicly available. The overall goal of this transparency is to make particular potential financial conflicts of interest more transparent. However, there are still considerable problems

with the current implementation of Open Payments, including the lack of guidance and clarity regarding the physician registration process, as well as the review and dispute process lacking necessary protections for physicians. Finally, a recent CMS proposed rule related to Open Payments would severely hamper the flow of information.

Registration Process Needs Sufficient Guidance, Clarity

CMS is encouraging physicians to register in CMS' Enterprise Portal (Enterprise Identification Management system or EIDM) and the Open Payments system in order to view the data reported by industry that will be made public on September 30, 2014. However, the CSRO is concerned that the lack of adequate notice before the beginning of registration periods has handicapped providers who hope to participate in the program in a meaningful manner. Given the importance of sufficient participation levels and the role of physicians in ensuring data integrity, the CSRO is concerned that the failure to provide sufficient notice could be a detriment to the program's performance. Further, members of the provider community have legitimate worries about the lack of guidance and the complexity of enrollment mechanisms. **We respectfully ask that CMS provide additional provider-specific guidance for the registration process and adopt policies that allow for flexibility of enrollment requirements so that physicians struggling to enroll remain able to participate in a meaningful manner.**

Review and Dispute Process Lacks Necessary Protections for Physicians and Teaching Hospitals

From July 14 through August 27, 2014, physicians and teaching hospital representatives can review and dispute data submitted about them before public release on September 30, 2014.

As part of that dispute resolution process, the CSRO requests an impartial process to dispute the accuracy of financial information intended for public disclosure. Specifically, the CSRO asks CMS to assume responsibility for ensuring the validity of published data as a means of both enhancing the integrity of the information and lessening burdens on providers in the absence of a uniform dispute process. Unfortunately, CMS recently made clear that the burden of disputes and adjudication falls entirely on health care providers and industry.

In the absence of a well-defined reconciliation process, the CSRO believes that CMS should safeguard the mission of the Open Payments program by taking steps to limit the publication of false or misleading information that can negatively impact the reputations of high quality physicians and impair patient decision-making. In its guidance to providers, CMS stated that information under dispute without reconciliation will nonetheless be posted online for public viewing with a disclaimer. The CSRO believes that the disclaimer offered by CMS fails to sufficiently protect the reputation of health professionals and publishes potentially false and actionable information that could impact a patient's decision to choose or not choose that provider.

As the collector and publisher of financial information, we respectfully ask that CMS take steps to enhance the fairness and accuracy of the Open Payments program by ensuring that health care providers have access to a meaningful mechanism for limiting the distribution of disputed information. Current standards fail to meet these goals by creating a reporting system where the default result of any dispute is publication, whether with or without a disclaimer. Such a process fails to fully consider the significant weight that patients may place

on the information published by CMS and the prejudicial effect that even disputed information can have on health care decision-making.

Changes to Continuing Medical Education (CME)

As I mentioned earlier in my testimony, certain educational presentations can provide valuable information regarding the latest and state of the art science. In my earlier example, our colleague relied on information from a scientific, educational lecture that led to an alternative treatment for his patient who had an inadequate response to more traditional therapy. In recognition of that valuable exchange of information, in previous rulemaking related to Open Payments, CMS clarified that speaker compensation at certain CME events is not required to be reported by an applicable manufacturer if all of the following criteria were met: (1) the CME program meets the accreditation or certification requirements and standards of the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, the American Dental Association's Continuing Education Recognition Program, the American Medical Association, or the American Osteopathic Association; (2) the applicable manufacturer does not select or suggest the covered recipient speaker nor does it provide the third party vendor with distinct, identifiable individuals to be considered as speakers for the accredited or certified continuing education programs; and (3) the applicable manufacturer does not directly pay the covered recipient speaker. However, as part of the CY 2015 Medicare Physician Fee Schedule (MPFS) proposed rule, CMS proposed to eliminate the CME exception for certain CME activities and instead rely on a standard related to whether the applicable manufacturer "does not know" or is "unaware" of the compensation. This less defined standard does not afford clarity and fails to acknowledge the value of CME. Further, this action reverses a decision that CMS

had previously reached after reviewing hundreds of stakeholder comments in a comprehensive rulemaking process. This decision, if finalized, would significantly disrupt the practice of CME and the confidence of doctors, educators and others. For this and many other reasons, **the CSRO urges Congress and others to ask CMS to reconsider its proposal to eliminate this exception and urge CMS to opt instead to appropriately expand the list of certified CME accrediting/issuing agencies beyond the five currently cited in regulation.**

SUMMARY

As I hope I have outlined today, current practices at both the FDA and CMS may be inappropriately hampering the exchange of information and making it difficult for physicians to receive the information they need to make valuable treatment decisions. For the FDA, I hope that Congress will examine ways to allow for more proactive exchanges among clinicians with appropriate safeguards to assure that such information is truthful and not misleading. For CMS, I hope that Congress can urge specific programmatic changes to make the transparency process accurate and appropriately descriptive of the financial relationships among the various entities.

Thank you again for taking into consideration our written comments. The Coalition of State Rheumatology Organizations looks forward to working with the Committee to address these issues.

Physician-Directed Applications

A Position Statement of the Alliance of Specialty Medicine

Physician-Directed Applications

Physician-directed applications, also known as "off-label"[1] uses, are an integral component of the art and science of medical practice, particularly for specialty physicians. Using their medical expertise and judgment, physicians may choose to use approved medical products such as prescription drugs, biologics, and devices, for uses not listed in the United States Food and Drug Administration (FDA) approved or cleared labeling, as appropriate.

Background

It is not uncommon for some off-label uses of medical products to become standard of care in the practice of medicine.[2] In fact, off-label uses of certain medical devices and drugs can be found in standard textbooks for medical subspecialties. In certain patient populations, such as children and cancer patients, off-label use of medical products is extensive when appropriate therapies have not been developed or evaluated for the populations or a clinical trial is not feasible (such as in the case of rare diseases). In these circumstances, physician-directed applications provide treatments that may not otherwise be available for some of the nation's youngest and most critically ill patients.

Physicians use the best available clinical evidence, judgment, and consideration of individual patient circumstances and preferences in treating and managing disease and injury. Good medical practice and the best interests of the patient require that physicians use legally-available drugs, biologics, and devices according to their best clinical expertise and judgment.

FDA Regulatory Principles and Labeling

The FDA has broad regulatory authority over the approval of pharmaceutical, medical device, and biologic products in the United States. Products may only be labeled, promoted, and advertised for the uses that the FDA has approved or cleared. Labeling of a medical product is negotiated between the FDA and the manufacturer to ensure that the labeling accurately reflects the safety and effectiveness data presented in the manufacturer's

[1] "Off-label" use for approved prescription drugs, biologics, and medical devices means any use that is not specified in the labeling approved by the FDA. For cleared medical devices, "off-label" means any use that is not included in the cleared "indications for use." Labeling is considered as any written material, which accompanies, supplements, or explains the product.

[2] Refer to specific specialty examples document at specialtydocs.org

marketing application. Furthermore, a drug, device, or biologics manufacturer may choose, for economic reasons, not to pursue additional labeling for indications that may increase the cost of obtaining FDA approval or clearance. As a result, the label may not reflect changes in indications, contraindications, warnings, or dosage, supported by new data that become available after approval or clearance.

Practice of Medicine Exception

The Food and Drug Administration does not have the statutory authority to regulate the practice of medicine. In 1998, the US Supreme Court issued a judgment in *Buckman v. Henney* affirming physicians' right to use any FDA-approved therapies they believe are in the best interests of their patients. In addition, section 906 of the federal Food, Drug, and Cosmetic Act addresses the issue of the practice of medicine and states the following:

> *Nothing in this Act shall be construed to limit or interfere with the authority of a health care practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate health care practitioner-patient relationship. This section shall not limit any existing authority of the Secretary to establish and enforce restrictions on the sale or distribution, or in the labeling, of a device that are part of a determination of substantial equivalence, established as a condition of approval, or promulgated through regulations. Further, this section shall not change any existing prohibition on the promotion of unapproved uses of legally marketed devices.*

Physicians may prescribe or administer any legally-marketed product for an off-label use within the practice of medicine.

Standards of Care

Standards of care change over time, and the emergence of new literature may alter treatment patterns. As a result, there are instances when the off-label use of medical products evolves to be recognized as a generally accepted medical standard. There are also instances in which the labeled uses of medical products are found to have contraindications and interactions that reduce their safety and efficacy. Specialty physicians are encouraged to notify the relevant agency or institution of adverse events related to the use of medical products.

Access to Available Information

To enhance patient care, physicians must have unrestricted access to truthful, non-misleading information about the benefits and risks of all therapies available for treatment, including medically accepted alternative uses of approved prescription drugs, biologics, and/or devices. Manufacturers must be able to provide adequate directions for use of both approved and medically accepted alternative indications of approved medicines and treatments, along with adequate disclosures regarding risks and the limitations of scientific

understanding.

Provided there is prominent disclosure that FDA does not approve such use, limitations on communications should only be related to patient risk based on factors including the approval status of the medicine, general medical acceptance of the treatment, and the level of scientific sophistication of the audience.

Informed Consent

Informed consent is the process by which the treating health care provider discloses appropriate information to a competent patient so that the patient may make a voluntary choice to accept or refuse treatment.[3] Among other things, informed consent requires a discussion of reasonable alternatives to the proposed intervention, which may include a discussion of medically accepted alternative uses of approved prescription drugs, biologics, or devices.

Physicians and medical institutions have varied practices for obtaining and documenting informed consent provided to patients that may or may not address off-label use. In some instances where an off-label use has come to be considered a standard of care in the clinical community and/or raises little risk of an adverse outcome, the use may not be discussed specifically with the patient. However, physicians should use their clinical judgment in determining the need to discuss specific off-label uses with patients and include information about such uses in informed consent materials when the off-label use could be a significant factor in the patient's decision about whether to undergo the procedure. If a patient has questions, the physician should also personally inform the patient that the product is being used in an off-label manner and discuss the benefit/risk profile for that use. This approach not only serves the patient's best interests, but might also help to limit the physician's liability risk.

Benefits and Risks of Physician-Directed Applications

Benefits and risks exist with off-label use. Benefits include the ability to provide care to patients who may not receive appropriate treatment or perhaps treatment at all without off-label use, such as many pediatric patients. Risks include the potential for limited effectiveness and unexpected side-effects from uses that have not been adequately studied for the specific indication or patient population.

It is well-established that physicians who use a product for an indication not in the approved or cleared labeling have the responsibility: (1) to be well informed about the product; (2) to base its use on a firm scientific rationale and sound medical evidence; and (3) to maintain awareness of the product's uses and effects.

[3] Appelbaum PS. Assessment of patient's competence to consent to treatment. *New England Journal of Medicine.* 2007; 357: 1834-1840.

Conflicts of Interest

Conflicts of interest should be disclosed in compliance with all state and federal laws and regulations. Specialty physicians engaging in compensated arrangements with industry should disclose their financial arrangements in medical education, research, and professional activities. Physicians who are involved in product development and/or testing should disclose this role to patients. Physicians should avoid interactions and activities where discussions of off-label use could be considered promotional in nature.

Statement of Policy

The Alliance of Specialty Medicine maintains that a specialty physician may prescribe or administer any legally-marketed product for an off-label use within the authorized practice of medicine where the physician exercises appropriate medical judgment and it is in the best interests of the patient. If specialty physicians use a product for an indication not in the approved or cleared labeling, they have the responsibility: (1) to be well informed about the product; (2) to base its use on a firm scientific rationale and sound medical evidence; and (3) to maintain awareness of the product's use and effects. Specialty physicians should appropriately counsel patients about the benefits and risks of the proposed treatment, and whether alternative treatments might be available. Specialty physicians are encouraged to notify the relevant agency or institution of adverse events related to the use of medical products.